ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C.

MICHAEL R. DEMERS, M.D.; STEVEN J. CUSICK, M.D.; KENNETH R. CERVONE, M.D.; BENEDETTO P. PELLERITO, M.D.;
JAMES D. BOOKOUT, M.D.; SHARIFF K. BISHAI, D.O.; ANDREW F. AJLUNI, D.O.; SAMER G. SAQQA, D.O.;
ANTHONY P. CUCCHI, D.O.; MATTHEW M. BREWSTER, D.O.

24715 LITTLE MACK AVENUE, SUITE 100
ST. CLAIR SHORES, MI. 48080
(586) 779-7970
(586)779-7748 (FAX)

WWW.ASSOCIATEDORTHO.ORG

50505 SCHOENHERR ROAD, SUITE 120
SHELBY TOWNSHIP, MI. 48315
(586) 412-1411
(586) 412-4626 (FAX)

NEW PATIENT HISTORY FORM

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY, STATE, ZIP: _____AGE: _____ SSN: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

EMERGENCY CONTACT NAME: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____SUBCRIBER NAME: _____

SUBSCRIBER D.O.B.:_____ SSN: _____RETIRED: _____Y _____N

SUBSCRIBER EMPLOYER: _____

SECONDARY INSURANCE: _____SUBCRIBER NAME: _____

SUBSCRIBER D.O.B.:_____ SSN: _____RETIRED: _____Y _____N

SUBSCRIBER EMPLOYER: _____

DO YOU HAVE AN HMO INSURANCE? ____YES ____ NO (IF YES, YOU MUST HAVE YOUR REFERRAL OR YOUR APPOINTMENT WILL BE CANCELLED)

**YOU MUST PROVIDE US WITH THE INSURANCE INFORMATION AT THE TIME OF YOUR APPOINTMENT. FOR ANY WORK, AUTO AND/OR LIABILITY INJURY IN ORDER TO BE SEEN. ACCORDING TO INSURANCE GUIDELINES, WHICH WE MUST FOLLOW, WE MAY NOT BILL HEALTH INSURANCE FOR THESE TYPES OF INJURIES, UNLESS A SPECIAL COORDINATION OF BENEFITS EXIST WITH YOUR HEALTH INSURANCE.

RESPONSIBLE PARTY

NAME: _____D.O.B._____SSN:_____

ADDRESS (IF DIFFERENT):_____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

FAMILY DOCTOR/INTERNIST:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

SEND THEM A LETTER: _____ Y _____ N

PHONE # (_____) _____

PHARMACY NAME: _____

WHO REFERRED YOU TO US?

NAME: _____

ADDRESS: _____

CITY, STATE, and ZIP: _____

SEND THEM A LETTER: _____ Y _____ N

PHONE # (_____) _____

PHARMACY PHONE #: _____

I AUTHORIZE ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C. TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS BE MADE TO SPECIALIST IN ORTHOPAEDIC SURGERY FOR SERVICES RENDERED. I AGREE TO PAY MY CO-PAYS, DEDUCTIBLES AND ANY BALANCE THAT IS DENIED OR IN DISPUTE BY MY INSURANCE COMPANY.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT, IF OTHER THAN SELF_____

NAME: _____ DATE: _____

CHECK ALL THAT APPLY:

_____ INJURY ON THE JOB (IF YES, CLAIM #_____)

_____ AUTO ACCIDENT INJURY (IF YES, CLAIM #: _____)

_____ RECEIVING DISABILITY INCOME _____ LEGAL PROCEEDINGS PENDING
_____ RECEIVING WORKERS COMP _____ WORKING WITH REHAB NURSE

IMAGING: (CHECK ALL THAT APPLY, INCLUDES DATES IF KNOWN)

_____ MRI _____ _____ CT_____ _____ X-RAY_____ _____ MYELOGRAM _____
_____ BONE SCAN_____ _____ EMG_____ _____ BONE DENSITY_____

_____ DISCOGRAM_____

ARE YOU EMPLOYED? _____ YES _____ NO OCCUPATION: _____

DOES THIS PROBLEM KEEP YOU FROM WORKING? _____ YES _____ NO (IF YES, DATE LAST WORKED _____)

REASON FOR VISIT (CHIEF COMPLAINT): _____

DATE OF ONSET: _____ DESCRIBE THE ONSET AND/OR CAUSE OF YOUR PROBLEM? _____

_____

_____

_____

_____

HAVE YOU EVER HAD BACK OR NECK SURGERY? PLEASE LIST PROCEDURES AND DATES (PLEASE LIST ANY COMPLICATIONS/OUTCOME OF SURGERY):

_____

_____

_____

HOW LONG HAVE YOU HAD BACK/NECK PAIN? _____ YEARS _____MONTHS _____WEEKS

CIRCLE THE NUMBER ON THE LINE THAT BEST DESCRIBES YOUR CURRENT BACK OR NECK PAIN

_____

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — MODERATE PAIN — SEVERE PAIN

NAME: _____ DATE: _____

HOW LONG HAVE YOU HAD ARM/LEG PAIN? _____ YEARS _____ MONTHS _____ WEEKS

CIRCLE THE NUMBER ON THE LINE THAT BEST DESCRIBES YOUR CURRENT ARM OR LEG PAIN

_____

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — MODERATE PAIN — SEVERE PAIN

DESCRIBE THE CHARACTER (QUALITY) OF YOUR PAIN:

ACHING	SHARP	EXHAUSTING	VICIOUS	THROBBING
PINCHING	TINGLING	PENETRATING	BURNING	PUNISHING
LANCINATING	TEARING	DULL	SHOOTING	STABBING
PRESSURE				

OTHER: _____

WHAT MAKES YOUR PAIN BETTER?

_____ LYING DOWN	_____ MANIPULATION	_____ PHYSICAL THERAPY	_____ SITTING
_____ EXERCISE	_____ ASPIRIN	_____ STANDING	_____ PRESCRIPTION PAIN PILLS
_____ TYLENOL	_____ WALKING	_____ MUSCLE RELAXERS	_____ OVER THE COUNTER MEDS

OTHER: _____

WHAT MAKES THE PAIN WORSE?

_____ LYING DOWN	_____ SNEEZING	_____ EXERCISE	_____ SITTING
_____ COUGHING	_____ STANDING	_____ BENDING FORWARD	
_____ WALKING	_____ BENDING BACKWARD		

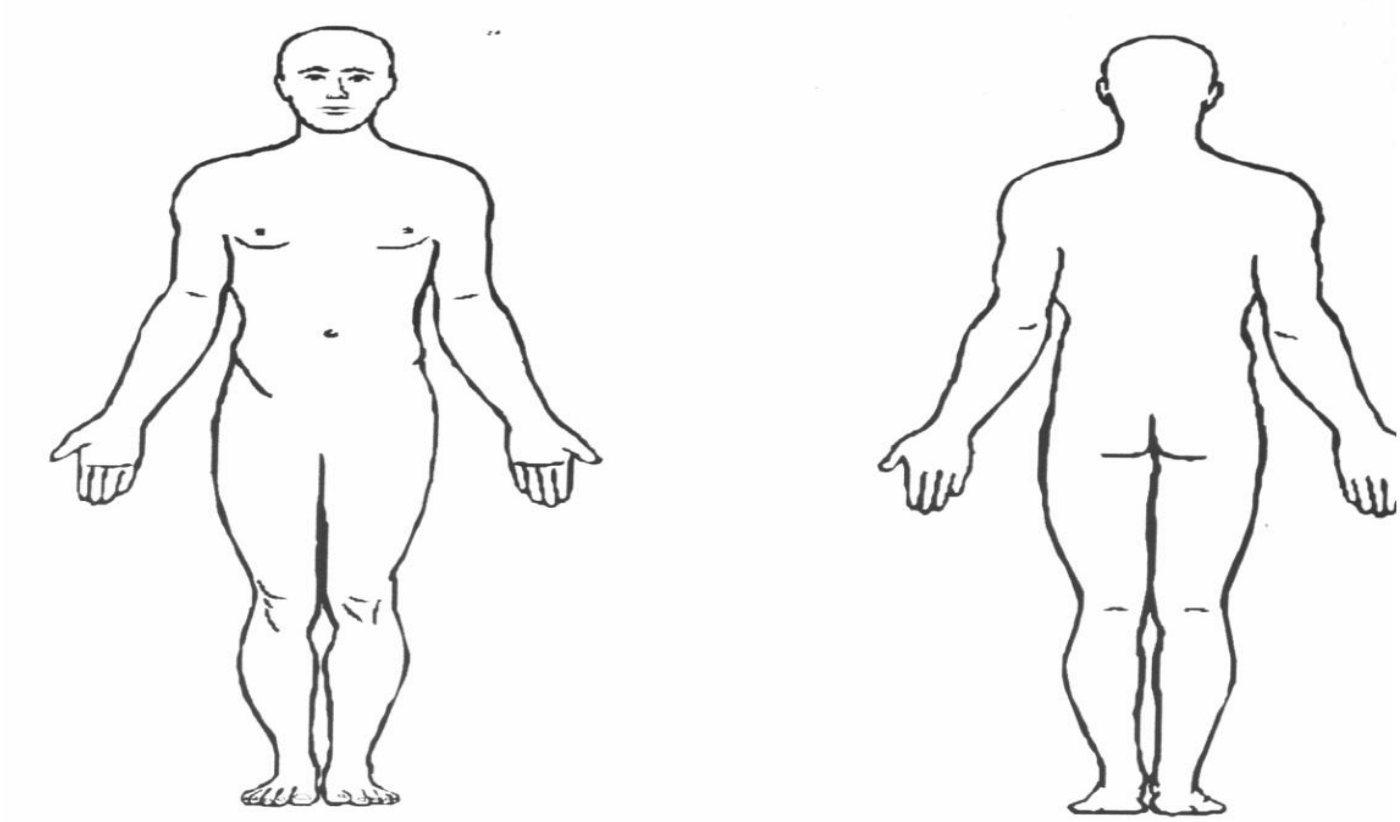
OTHER: _____

HOW FAR CAN YOU WALK? _____BLOCKS (NUMBER_____) _____ AROUND THE HOUSE

_____ UNLIMITED _____ OTHER: _____

NAME: _____DATE:_____

MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT (IF THE BACK OF YOUR NECK HURTS, MARK THE BACK OF YOUR NECK, ETC.). If YOU FEEL ANY OF THE FOLLOWING SYMPTOMS, PLEASE INDICATE WHERE YOU FEEL THEM BY PLACING THE MARKS SHOWN HERE ON THE DIAGRAM. IF THE MARKINGS ARE NOT APPLICABLE, INDICATE THE AREAS OF PAIN IN YOUR OWN WORDS. NUMMBNESS ==== BURNING xxxx STABBING //// ACHE - - - - PINS & NEEDLES 0 0 0 0



WHO HAVE YOU SEEEN FOR TREATMENT OF PAIN/SYMPTOMS IN THE PAST? (PLEASE LIST NAMES)

PRIMARY CARE DOCTOR: _____

ORTHOPAEDIC SPINE SURGEON: _____

NEUROSURGEON: _____

REHAB DOCTOR: _____

NEUROLOGIST: _____

EMERGENCY ROOM DOCTOR: _____

PAIN CLINIC: _____

CHIROPRACTOR: _____

PHYCHOLOGIST: _____

PSYCHIATRIST: _____

OTHER: _____

NAME: _____DATE:_____

WHAT TREATMENTS HAVE YOU TRIED FOR PAIN RELIEF: (CHECK ALL THAT APPLY)

	DID IT HELP?			DID IT HELP?	
_____ PHYSICAL THERAPY	YES	NO	_____TAKEN TIME OFF OF WORK	YES	NO
ATTENDED THERAPY FOR HOW LONG? _____			_____ WORN A BRACE	YES	NO
_____ AQUA THERAPY	YES	NO	_____ ALTERED DAILY ACTIVITIES	YES	NO
_____ TRACTION	YES	NO	_____ RESTED	YES	NO
_____ MASSAGE	YES	NO	_____ USED ICE	YES	NO
_____ TENS UNIT	YES	NO	_____ USED HEAT	YES	NO
_____ ACUPUNCTURE	YES	NO	_____ NERVE BLOCK	YES	NO
_____ ANTI-INFLAMMATORY MEDS	YES	NO	_____ FACET BLOCK	YES	NO
HOW LONG DID YOU TAKE MEDICATION? _____			_____ ORAL STEROIDS	YES	NO
_____ PAIN MEDICATIONS	YES	NO	_____ EPIDURAL STEROID INJECTIONS	YES	NO

PAST MEDICAL HISTORY/FAMILY HISTORY (CHECK ALL THAT APPLY)

YOU	FAMILY		YOU	FAMILY	
____	_____	HEART ATTACK	____	_____	BLEEDING PROBLEM
____	_____	HEART FAILURE	____	_____	STRESS TEST
____	_____	HIGH BLOOD PRESSURE	____	_____	CANCER*
____	_____	STROKE	____	_____	HEPATITIS ____A ____B ____C
____	_____	KIDNEY DISEASE	____	_____	PUMONARY EMBOLUS
____	_____	HEART CATHERIZATION	____	_____	BLOOD CLOTTING
____	_____	DIABETES	____	_____	HIGH CHOLESTEROL
____	_____	ANEMIA	____	_____	ARTHRITIS
____	_____	ASTHMA	____	_____	BLADDER/PROSTATE PROBLEMS
____	_____	BLOOD TRANSFUSION	____	_____	EMPHYSEMA
____	_____	EPILEPSY	____	_____	FIBROMYALGIA
____	_____	HEADACHE/MIGRAINE	____	_____	GALL BLADDER
____	_____	HEAD INJURY	____	_____	HEARING PROBLEMS
____	_____	HIATAL HERNIA	____	_____	LIVER DISEASE/JAUNDICE
____	_____	MENINIGITIS	____	_____	MULTIPLE SCLEROSIS
____	_____	PNEUMONIA	____	_____	POLIO
____	_____	RHEUMATIC FEVER	____	_____	SCOLIOSIS
____	_____	SEIZURES	____	_____	THYROID DISORDER
____	_____	TUBERCULOSIS	____	_____	ULCERS
____	_____	WEAKNESS/PARALYSIS	____	_____	

*IF YOU ANSWERED YES TO CANCER, WHAT TYPE AND WHO HAD IT: _____

_____

_____

NAME: _____DATE:_____

DO YOU HAVE ANY MEDICAL CONDITIONS NOT LISTED ABOVE? (PLEASE LIST):_____

_____

_____

HAND DOMINANCE: _____ RIGHT _____ LEFT HEIGHT: _____ WEIGHT: _____

PLEASE LIST ALL ALLERGIES: DO YOU HAVE ANY METAL ALLERGIES? _____ YES _____NO _____ NO ALLERGIES

_____

_____

_____

PLEASE LIST ALL PAST SURGERIES: (INCLUDE DATES IF KNOWN):_____

_____

_____

_____

SOCIAL HISTORY:

MARITAL STATUS: S M W D FEMALES-ARE YOU PREGNANT? _____ YES _____ NO

DO YOU SMOKE? _____ YES _____ NO (# OF PACKS PER DAY _____ FOR HOW MANY YEARS _____)

HAVE YOU QUIT SMOKING? _____ YES _____ NO (WHEN DID YOU QUIT? _____)

DO YOU USE OTHER FORMS OF TOBACCO? _____ YES _____ NO (IF YES, WHAT? _____)

DO YOU DRINK ALCOHOL? _____ YES _____ NO (# OF DRINKS WEEKLY _____)

DO YOU HAVE AIDS/HIV? _____ YES _____NO **HAVE YOU EVER BEEN TESTED?** _____ YES _____ NO

DO YOU LIVE IN A? _____ 1 STORY _____ 2 STORY _____CONDO _____ HOUSE _____ APARTMENT

DO YOU LIVE _____ ALONE _____ WITH FAMILY _____ WITH FRIENDS

DO YOU USE RECREATIONAL DRUGS? _____ YES _____ NO IF YES, WHAT KIND? _____

DO YOU USE MARIJUANA? _____ YES _____ NO IF YES, _____ MEDICALLY PRESCRIBED _____ RECREATIONAL

DO YOU USE AN ASSISTIVE DEVICES? _____CANE _____WALKER _____WHEELCHAIR _____CRUTCHES _____NONE

MEDICATIONS (PLEASE LIST ALL MEDICATIONS WITH DOSAGES AND STRENGTHS TO INCLUDE PRECRIPTION, VITAMINS, HERBAL)

_____

_____

_____

_____

_____

_____

_____

I CURRENTLY TAKE NO MEDICATIONS: _____

NAME: _____DATE:_____

DO YOU NOW OR HAVE YOU RECENTLY HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTMES? CHECK "YES" OR "NO". IF YOU MARK YES TO ANY OF THE FOLLOWING, PLEASE INDICATE WHICH DOCTOR IS TREATING YOU FOR THAT PROBLEM. IF YOU HAVE NOT SEEN A PHYSICIAN YET, PLEASE CONTACT YOUR INTERNIST OR FAMILY PHYSICIAN TO ADDRESS THESE ISSUES.

ALLERGIC/IMMUNOLOGICAL:

_____ YES _____ NO HAY FEVER

_____ YES _____ NO DRUG ALLERGIES

_____ YES _____ NO ALLERGIC SEIZURE

OTHER: _____

CARDIOVASCULAR:

_____ YES _____ NO CHEST PAIN

_____ YES _____ NO VARICOSE VEINS

_____ YES _____ NO LEG SWELLING

_____ YES _____ NO IRREGULAR HEARTBEAT

OTHER: _____

CONSTITUTIONAL SYMPTOMS:

_____ YES _____ NO FEVER

_____ YES _____ NO CHILLS

_____ YES _____ NO HEADACHE

OTHER: _____

EAR/NOSE/THROAT/MOUTH:

_____ YES _____ NO EAR PROBLEMS

_____ YES _____ NO SORE THROAT

_____ YES _____ NO SINUS PROBLEM

OTHER: _____

ENDOCRINE:

_____ YES _____ NO EXCESSIVE THIRST

_____ YES _____ NO TOO HOT OR COLD

_____ YES _____ NO TIRED OR SLUGGISH

OTHER: _____

EYES:

_____ YES _____ NO BLURRED VISION

_____ YES _____ NO DOUBLE VISION

_____ YES _____ NO PAIN

OTHER: _____

GASTROINTESTINAL:

_____ YES _____ NO ABDOMINAL PAIN

_____ YES _____ NO NAUSEA OR VOMITING

_____ YES _____ NO INDEGESTION OR HEARTBURN

OTHER: _____

GENITOURINARY:

_____ YES _____ NO URINE RETENTION

_____ YES _____ NO PAINFUL URINATION

_____ YES _____ NO URINARY FREQUENCY

OTHER: _____

HEMATOLOGICAL/LYMPHATIC:

_____ YES _____ NO SWOLLEN GLANDS

_____ YES _____ NO BLODD CLOTTING PROBLEMS

OTHER: _____

INTEGUMENTARY:

_____ YES _____ NO SKIN RASH

_____ YES _____ NO BOILS

_____ YES _____ NO PERSISTENT ISSUE

OTHER: _____

MUSCOSKELETAL:

_____ YES _____ NO JOINT PAIN

_____ YES _____ NO NECK PAIN

_____ YES _____ NO BACK PAIN

OTHER: _____

NEUROLOGICAL:

_____ YES _____ NO SEIZURES

_____ YES _____ NO TREMORS

_____ YES _____ NO DIZZY SPELLS

OTHER: _____

PSYCHOLOGICAL:

_____ YES _____ NO DO SUFFER FROM DEPRESSION

_____ YES _____ NO DO YOU FEEL SEVERELY ANXIOUS OR NERVOUS

OTHER: _____

RESPIRATORY:

_____ YES _____ NO WHEEZING

_____ YES _____ NO FREQUENT COUGH

_____ YES _____ NO SHORTNESS OF BREATH

OTHER: _____

PATIENT'S SIGNATURE: _____ DATE: _____

ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C.

MICHAEL R. DEMERS, M.D.; STEVEN J. CUSICK, M.D.; KENNETH R. CERVONE, M.D.; BENEDETTO P. PELLERITO, M.D.;
JAMES D. BOOKOUT, M.D.; SHARIFF K. BISHAI, D.O.; ANDREW F. AJLUNI, D.O.; SAMER G. SAQQA, D.O.;
ANTHONY P. CUCCHI, D.O.; MATTHEW M. BREWSTER, D.O.

24715 LITTLE MACK AVENUE, SUITE 100
ST. CLAIR SHORES, MI. 48080
(586) 779-7970
(586)779-7748 (FAX)

WWW.ASSOCIATEDORTHO.ORG

50505 SCHOENHERR ROAD, SUITE 120
SHELBY TOWNSHIP, MI. 48315
(586) 412-1411
(586) 412-4626 (FAX)

AUTHORIZATION FOR USE OR DISCLOSURE OF (PHI) PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), Protected Health Information, under federal health privacy law, as described below.

I, _____authorize Associated Orthopedists of Detroit, P.C. to release and obtain my private health information to/from (check all that applies):

☐ My spouse/partner — Name of spouse/partner: _____

☐ My Primary Care Physician/Staff — Name of Physician: _____

☐ My Pharmacy — Name of Pharmacy: _____

☐ My Parent/Child (ren) — Name: _____

☐ My Personal Representative — Name of Representative: _____

☐ Other — Name: _____

☐ Other — Name: _____

☐ None of the above.

May our office leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Are there any restrictions on PHI to be disclosed? ☐ Yes ☐ No

If Yes:

_____

_____

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Associated Orthopedists of Detroit, P.C. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Edwin Padilla, CMA 24715 Little Mack Ave. #100, St. Clair Shores, Mi. 48080. I understand that my revocation will not affect any actions taken by Associated Orthopedists of Detroit, P.C. prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party. This authorization shall be effective one year from the date signed. At which time this authorization to obtain and release this Protected Health Information expires.

Patient Signature/Authorized Representative: _____

Print Patient's Name: _____

Date: _____